



Division of Higher Learning  
*Associated Beth Rivkah Schools*

310 Crown Street  
 Brooklyn, New York 11225  
 (718) 735-0400 [DHLSeminary@Bethrivkah.edu](mailto:DHLSeminary@Bethrivkah.edu)

**APPLICATION REQUIREMENTS 2018/2019**

- **Application for Admission.** Please use your **full legal name** as it appears on your **Social Security card** (foreign students use name on **Passport**)
- Include a copy of your **Social Security card** and **passport**
- **Your signature on all forms should be your legal first and last name in script**
- Student Applicant Questionnaire
- A photo from the past year.
- Copy of your **high school transcript and diploma**
- Copy of transcripts from all postsecondary schools you attended
- **2** Letters of recommendation from your principal and Rabbi, to be sent directly to our office
- Personal Interview with the Dean after application is submitted. Please call for an appointment or email [dhlseminary@bethrivkah.edu](mailto:dhlseminary@bethrivkah.edu)

***Original Forms should be mailed with application fee to:***

Mrs. Chana Gorowitz, Dean  
 ABRS, Division of Higher Learning  
 310 Crown Street  
 Brooklyn, NY 11225-3004  
 Email: [DHLSeminary@bethrivkah.edu](mailto:DHLSeminary@bethrivkah.edu)

Fax copies or scans from a phone **are not acceptable**. Scans must be **clear** and **legible**.

**FOR FOREIGN STUDENTS ONLY:** Please see [Information Regarding I-20 Student Visa](#)

Students entering the U. S. on tourist visas will **NOT** be admitted.

**Tuition and Fees**

**Application Fee \$100: non-refundable**

**TUITION COSTS: 2018-2019 /5779**

(Does not include room and board)

**DHL 1** (sem aleph)

<b>Student Activity Fee</b>	<b>\$500</b>
<b>Tuition</b>	<b>\$8300</b>
<b>Maalot Credit option</b>	<b>\$550</b>

**DHL 2** (sem bais)

<b>Student Activity Fee</b>	<b>\$300</b>
<b>Tuition</b>	<b>\$7800</b>
<b>Intensive Teacher Training Early Childhood option</b>	<b>\$1400</b>
<b>Intensive Teacher Training Elementary option</b>	<b>\$1900</b>
<b>Maalot Credit option</b>	<b>\$550</b>

For additional information:

Please contact Mrs. Yocheved Baitelman 718 735-0400 x1120 or Mrs. Zisel Gurevitz at 718 735-0400 x1121 or email [DHLSEMINARY@bethrivkah.edu](mailto:DHLSEMINARY@bethrivkah.edu).



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**APPLICATION FOR ADMISSION**

**Fall 2018**

**Spring 2019**

**PERSONAL DATA** [PLEASE TYPE OR PRINT CLEARLY]:

LEGAL NAME \_\_\_\_\_ AKA \_\_\_\_\_ HEBREW NAME \_\_\_\_\_  
Last First  
 BIRTHDATE \_\_\_\_\_ HEBREW BIRTHDATE \_\_\_\_\_ MAIDEN NAME \_\_\_\_\_  
 SOCIAL SECURITY NUMBER \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL# \_\_\_\_\_  
 STUDENT'S EMAIL \_\_\_\_\_ PARENT'S EMAIL \_\_\_\_\_  
 PERMANENT HOME ADDRESS \_\_\_\_\_  
 PLACE OF BIRTH \_\_\_\_\_ ARE YOU A U.S. CITIZEN?  YES  NO (IF NO, COMPLETE NEXT SECTION)

COUNTRY OF CITIZENSHIP _____	COUNTRY OF RESIDENCY _____
<input type="checkbox"/> ALIEN REGISTRATION NUMBER _____	<input type="checkbox"/> VISA TYPE _____

PLEASE LIST **HIGH SCHOOLS** ATTENDED

NAME OF SCHOOL	LOCATION (CITY, STATE)	DATE GRADUATED or Anticipated Graduation Date
		Month _____ Year _____

LIST ALL POSTSECONDARY SCHOOLS YOU PREVIOUSLY ATTENDED OR ARE CURRENTLY ENROLLED IN (INCLUDE SEMINARIES, COLLEGES & VOCATIONAL SCHOOLS).

SCHOOL	LOCATION	FROM	TO	CREDITS / DEGREE EARNED

*I hereby apply for enrollment as a regular student at Associated Beth Rivkah School, DHL for the purpose of obtaining a Classical Torah Studies Degree. I certify that all the information contained on this application is accurate and complete to the best of my knowledge. I further understand that I must remain in compliance with all of Associated Beth Rivkah Schools' rules and regulations as described in the bulletin and other official notices and publications.*

\_\_\_\_\_  
**SIGNATURE OF APPLICANT** (FULL LEGAL NAME)

\_\_\_\_\_  
 DATE

**FOR OFFICE USE ONLY:**

ACCEPTED \_\_\_\_\_ LEVEL \_\_\_\_\_ CREDITS ACCEPTED \_\_\_\_\_

CONFIRMED BY \_\_\_\_\_ DATE \_\_\_\_\_

**Associated Beth Rivkah Schools - Division of Higher Learning**  
**310 Crown Street, Brooklyn, NY 11225**  
**Student Applicant Questionnaire 2018/2019 5779**

**Family Information**

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_

Hebrew Name: \_\_\_\_\_ Mother's Hebrew Name \_\_\_\_\_

Applicant's Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Email \_\_\_\_\_ Mother's Email \_\_\_\_\_

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Mother's Name \_\_\_\_\_ Mother's Maiden Name \_\_\_\_\_ Occupation \_\_\_\_\_

Home Address \_\_\_\_\_

**Brothers:** Older \_\_\_ Younger \_\_\_ **Sisters:** Older \_\_\_ Younger \_\_\_ Are any of your siblings married? \_\_\_\_\_

Was your mother born Jewish? \_\_\_Yes \_\_\_No If "no" Please enclose a copy of your mother's conversion papers.

Were you born Jewish? \_\_\_Yes \_\_\_No If "no" Please enclose a copy of your conversion papers.

**Social**

Do you have a *Mashpia*? \_\_\_\_\_

Did you arrange or participate in extra curricular activities? If yes, please specify. \_\_\_\_\_

Where did you spend you summers since 9<sup>th</sup> grade?

**Academic**

High Schools Attended \_\_\_\_\_

Seminary Attended \_\_\_\_\_

What is your favorite subject in high school? \_\_\_\_\_

What is your strongest subject in high school? \_\_\_\_\_

What is your weakest subject in high school? \_\_\_\_\_

**Sem Bais Applicants**

Are you interested in Intensive Teacher Training? \_\_\_ Yes \_\_\_ No If yes, please request and submit a **Teacher Training Application**.

Are you interested in training for teaching adult education? \_\_\_ Yes \_\_\_ No This option is open regardless of whether you do Intensive Teacher Training or not.

**On the back of this page please write a paragraph on why you would like to attend Beth Rivkah DHL and what your expectations are (i.e. *Chassidishkeit*, academics, socially).**



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בס"ד

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**Student Health Declaration 2018/2019 5779**

Student's Name \_\_\_\_\_ Email Address \_\_\_\_\_

Student's Home address \_\_\_\_\_

Student's Hebrew Name \_\_\_\_\_ Mother's Hebrew Name \_\_\_\_\_

Medical Insurance Information (Valid in New York) - \_\_\_\_\_

Do you have a Dor Yeshorim #? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have frequent headaches or migraines? \_\_\_\_\_

Do you have any allergies? \_\_\_\_\_ If yes, please specify \_\_\_\_\_

Do you have any eating limitations? \_\_\_\_\_ If yes, please specify \_\_\_\_\_

Do you take any medications? \_\_\_\_\_ If yes, please specify \_\_\_\_\_

Do you have or have a history of health issues or illnesses? \_\_\_\_\_

Did you ever need psychological or psychiatric attention? \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone# \_\_\_\_\_

Emergency Contact in Crown Heights \_\_\_\_\_ Phone# \_\_\_\_\_

*I hereby authorize Beth Rivkah to make all decisions concerning Emergency Medical Treatment*

Student's Signature \_\_\_\_\_ Cell # \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Cell# \_\_\_\_\_

**PLEASE COMPLETE THE ENCLOSED  
STUDENT IMMUNIZATION RECORD FORM  
IT MUST BE SIGNED BY STUDENT/PARENT AND PHYSICIAN**



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**NEW IMMUNIZATION REQUIREMENT FOR STUDENTS  
 ATTENDING A NEW YORK STATE SCHOOL OF HIGHER EDUCATION**

Dear Students and Parents שיחיו ,

In accordance with New York State Public Health Laws, every student attending an institution of higher learning must submit the Meningitis Response Form and proof of immunity against measles, mumps and rubella prior to registering for classes.

**PLEASE NOTE THAT THE NYS BOARD OF HEALTH MAY ISSUE A \$2,000.00 FINE FOR EACH STUDENT WHO DOES NOT HAVE A RECORD OF IMMUNIZATIONS ON FILE!**

Enclosed please find the Associated Beth Rivkah, DHL Student Immunization Record Form. Please fill it out as follows:

**PART I MENINGITIS RESPONSE FORM** refers to the **meningococcal meningitis immunization (menomune or menectra)**.

If the student is under 18 years old, the parent must fill this out and sign it.

If the student is 18 years old or older, the student must fill it out and sign it.

**If your daughter is 18 years old or older and is not at home to sign, please return this form to our office after the doctor fills out his portion regarding the measles, mumps and rubella, and your daughter can complete this section and sign it when she comes to Beth Rivkah.**

**PART II** refers to the **measles, mumps and rubella immunity**, either with the immunizations, history of illness (this does not apply to rubella), or through immunization proven through serologic (blood) testing.

If the student is in the process of completing the requirements of these immunizations, she needs a certificate of immunization proving that she has received at least one dose each of the live measles, mumps and rubella virus vaccines and has an appointment to return to the health practitioner for the 2<sup>nd</sup> dose of the live measles virus vaccine within 90 days of the first measles vaccine.

Please take care of this matter as soon as possible.

**STUDENTS WILL NOT BE ADMITTED TO ORIENTATION WITHOUT A COMPLETED IMMUNIZATION FORM (see attached), SIGNED BY THE STUDENT/ PARENT AND DOCTOR.**

Thank you in advance for your cooperation,

Sincerely,

Yocheved Baitelman  
 DHL Office



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**STUDENT IMMUNIZATION RECORD FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Last 4 digits Social Security # \_ \_ \_ \_

Home Address \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Student's Cell Phone# \_\_\_\_\_ :

Student's E-mail \_\_\_\_\_ Parent's Email \_\_\_\_\_

**Part I – MENINGITIS RESPONSE FORM - to be checked, completed and signed by the student (or parent if student is under age 18)**

\_\_\_ I have had the meningococcal meningitis immunization (Menomune) within the past 10 years Date \_\_\_\_\_

\_\_\_ I will obtain immunization against meningococcal meningitis **within 30 days** from my private health provider.

\_\_\_ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will **not** obtain immunization against meningococcal meningitis disease.

Student / Parent Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Part II – Vaccination record to be completed and signed by a licensed health care provider.**

	MEASLES	MUMPS	RUBELLA	COMBINED MMR
Vaccination dates (Two doses required for measles or MMR)	Dose 1:			Dose 1:
	Dose 2:			Dose 2:
Scheduled date for Dose 2 of measles or MMR				
Disease History (date of onset)				
Serology date and result (Include copy of lab report)				

I certify that the above information is correct.

Health Care Provider Signature \_\_\_\_\_

Printed Name and Title \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Date \_\_\_\_\_